STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155654	A. BUILDING 01 B. WING _____	01/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENGLEWOOD HEALTH & REHABILITATION CENTER	2237 ENGLE ROAD FORT WAYNE, IN 46809

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 01/10/11 Facility Number: 000498 Provider Number: 155654 AIM Number: 100266110 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, Englewood Health and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor and areas open to the corridor. The facility has a capacity of 67 and had a census of 62 at the time of this survey. Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 01/19/11. APPROVED 2/8/11 DA The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:	K 000	**The following Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. Submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.** RECEIVED FEB - 3 2011 LONG TERM CARE DIVISION INDIANA STATE DEPARTMENT OF HEALTH	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rita Holloway	ADMINISTRATOR	2-1-11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Executive Director 2-1-11

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K 046 SS=B	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure 6 of 7 emergency lights of at least 1½ hour duration were tested annually in accordance with LSC 7.9. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test shall be conducted on every required battery powered emergency lighting system at 30 day intervals for a minimum of 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all occupants with the exception of those in the newer section of the 300 hall. Findings include: Based on an observation with the Maintenance Director on 01/10/11 from 11:00 a.m. to 1:45 p.m., battery operated emergency lights were observed at the central nurses' station, 100 hall, 200 hall, the emergency generator and three different locations on the 300 hall. Based on an interview with the Maintenance Director at 12:34 p.m., the only battery operated light tested for ninety minutes was the one on the new section of the 300 hall.	K 046	**K 046** i. The facility is replacing all battery operated lighting with lighting that will have a power source connected to the generator therefore eliminating all battery operated lighting. ii. All residents have the potential to be affected by the alleged deficiency. iii. The facility will test all battery operated emergency lighting: Monthly Test will be a 30 sec. test and the Annual Test will be for 90 min. All tests will be record on the TELS Electronic Record. iv. The facility has an electronic audit tool for the Maintenance Supervisor to do the monthly checks. Audits will be reviewed through Q.A. until 100% compliance is achieved. v. The facility will be in compliance by February 9, 2011.	

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K 046	Continued From page 2 3.1-19(b)	K 046		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 1 of the last 4 completed quarters. This deficient practice could affect all occupants. Findings include: Based on record review of the "Monthly Fire and Evacuation Alarm/Drill Report" with the Executive Director and Maintenance Director on 01/10/11 at 11:45 a.m., there was no record of a third shift fire drill for the first quarter of 2010. Based on an interview with the Maintenance Director at the time of record review, no other documentation was available for review to verify this drill was conducted.	K 050	**K 050** i. The facility will monitor the Maintenance Manual on a monthly basis for fire drill accountability. ii. All residents have the potential to be affected by the alleged deficiency. iii. The facility will in-service the Maintenance Supervisor on the importance of conducting fire drills monthly as well as varying shifts and drill times per month to include all shifts each quarter. iv. The Maintenance Manual will be reviewed on a monthly basis for fire drill accountability and the fire drills will be reviewed through Q.A. until 100% compliance is achieved. v. The facility will be in compliance by February 9, 2011.	
K 056 SS=F	3.1-19(b) NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is	K 056		

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K 056	Continued From page 3 installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure four rooms in 2 of 4 smoke compartments were equipped with one type of sprinkler head, i.e., quick response sprinklers or standard sprinklers. NFPA 13, 1999 Edition, Installation of Sprinkler Systems, 5-3.1.5.2 states when existing light hazard systems are converted to use quick response or residential sprinklers, all sprinklers in a smoke compartment shall be changed. This deficient practice could affect 17 residents on the 200 hall and staff in the kitchen. Findings include: Based on observations with the Maintenance Director on 01/10/11 between 1:12 p.m. and 1:40 p.m. the following rooms had a mixture of quick response sprinkler heads and standard response sprinkler heads: the kitchen and resident rooms 212, 210, 208, 206 and 204. This was acknowledged by the Maintenance Director at the time of each observation.	K 056	**K 056** i. The facility has arranged to replace all standard sprinkler heads to quick response sprinkler heads. ii. All residents have the potential to be affected by the alleged deficiency. iii. The facility will in-service the Maintenance Supervisor about the need to check all sprinkler heads semi-annually. iv. The facility has an electronic audit tool for the Maintenance Supervisor to check all sprinkler heads semi-annually. This will be reviewed through Q.A. until 100% compliance is achieved. v. The facility will be in compliance by February 9, 2011.	

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K 056	Continued From page 4 3.1-19(b)	K 056		